Agency Name & Phone Number

Stroke and CVD Risk Screening Form

Michigan Stroke Initiative

Please fill out the following information:
Sex: ☐ Male ☐ Female Age _____ Screening Location _____
Race/Ethnicity: ☐ African-American ☐ Hispanic ☐ Middle Eastern ☐ Caucasian ☐ Other_____

Please answer the questions below with either "yes or no." (* indicates risk factors with borderline high cholesterol)

Personal History: I have a history of coronary heart disease, heart attack, pulse irregularity, angina, stroke, carotid artery disease **or** TIA (mini-stroke). ☐ **NO** ☐ **YES***	***Family History:*** My father or brother had a heart attack before age 55 **or** my mother or sister had one before age 65; **or** my mother, father, sister, brother or grandparent had a stroke. ☐ **NO** ☐ **YES***
Blood Pressure: I have high blood pressure (140 systolic and/or 90 diastolic or higher), am on medication for high blood pressure. ☐ **NO** ☐ **YES***	***Age and Gender:*** I am a man over 45 years old **or** I am a woman over 55 years old **or** have passed menopause **or** had my ovaries removed**.** ☐ **NO** ☐ **YES***
Total Cholesterol: I have high total cholesterol (240 mg/dl or higher), am on medication **or** a special diet for my cholesterol**.** ☐ **NO** ☐ **YES**	***Diabetes:*** I have diabetes (a fasting blood sugar of 126 mg/dl or higher) **or** need medicine to control my blood sugar. ☐ **NO** ☐ **YES***
HDL Cholesterol: I have an HDL that is less than 40 mg/dl. ☐ **NO** ☐ **YES***	***Overweight:*** I am 20 pounds **or** more overweight for my height and build. ☐ **NO** ☐ **YES**
Tobacco: I currently smoke **or** live or work with people who smoke every day. ☐ **NO** ☐ **YES***	***Physical Activity:*** I get less than a total of 30 minutes of physical activity on most days. ☐ **NO** ☐ **YES**

RELEASE: By providing the foregoing information I represent that I understand and agree to the following: The information provided on this form is, to the best of my knowledge, complete and correct. Participation in this program may include taking a personal and family medical history, blood pressure readings, pulse rhythm check, cholesterol and or blood sugar tests; referring me to my health care provider and follow-up consultation. A low risk assessment is not a guarantee of good health, and participation in this program cannot substitute for consultation with a health car provider for any medical or health-related condition, or for regular physical examinations. I release and agree to hold harmless, the agency that is conducting or participating in this program, and any sponsors, their officers, directors, employees, agents, volunteers and representatives from any claims, liability or damages, including but not limited to personal injury or illness, arising in any way from my participation in this program. All medical information obtained in this program will be kept confidential and used by the agency for data collection and reporting in aggregate format.

Signature _____ Date _____
Print Name _____ Phone ( )_____ Witness _____

********** **STAFF USE ONLY** **********

TEST	RESULTS	RECOMMENDED RANGES	REFERRAL LEVELS	REFERRED?
BP	☐ On treatment now? 1st_____/_____ 2nd_____/_____ 3rd_____/_____	**Ideal:** Less than 120 systolic & Less than 80 diastolic	☐ High: 140-179 systolic or 90-109 diastolic ☐ Urgent: 180-209 systolic or 110-119 diastolic ☐ Emergency: 210 + systolic or 120 + diastolic **Prehypertensive: 120-139 systolic & 80-89**	☐No ☐Yes
Pulse Rhythm	☐ Regular ☐ Irregular	If irregular, it can increase the risk of a stroke.	Advise to see health care provider if irregular and is a new finding.	☐No ☐Yes
Chol. Total	☐ On treatment now? _____mg/dl	Total: Less than 200 mg/dl	Total: ☐ High: 240 mg/dl or greater ☐ Borderline High: 200-239 mg/dl. Refer if CHD history, diabetes or 2 or more risk factors(*)	☐No ☐Yes
_____ **HDL**	_____mg/dl analyzer # _____	HDL: 40 mg/dl or greater 60 mg/dl or greater is *very desirable*	HDL: ☐ 39 mg/dl or less	_____ ☐No ☐Yes
Blood Sugar	☐ On treatment now? _____mg/dl	Fasting: Less than 110 Nonfasting: Less than 140	☐ High fasting: 110 mg/dl or greater ☐ High nonfasting: 140 mg/dl or greater	☐No ☐Yes

ADVICE:

☐ **See your doctor for further evaluation1)** ☐ **within _____ days; 2)** ☐ **within the next few months; 3)**☐ **at your next visit**
FOR ☐blood pressure ☐ cholesterol ☐ blood sugar ☐ pulse rhythm ☐ other _____
To reduce your risks for cardiovascular disease consider making the following changes:
☐ quit smoking ☐ lose weight ☐ follow the DASH diet ☐ follow a low-fat diet ☐ become more active

Other: _____

Screener name:_____

Participant's Copy

This form was developed by the Michigan Stroke Initiative, MDCH, 2003